		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0010330

Facility Name: Rehab & Care Ctr-Jackson County

Address: 1441 North 14th Street (Number) Murphysboro (City) 62966 (Zip Code)

County: Jackson

Telephone Number: 618-684-2136 **Fax #** 618-684-5710

IDPA ID Number: 37-6001092-004

Date of Initial License for Current Owners:

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Mark Dallas **Telephone Number:** 618-529-1040

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/01 to 11/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Mark W. Dallas, CPA, Partner
(Firm Name & Address) Kerber, Eck, Braeckel LLP, 1116 W. Main St., Carbondale, Il 62903
(Telephone) 618-529-1040 Fax # 618-549-2311

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	202	Skilled (SNF)	202	73,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	202	TOTALS	202	73,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	5,564	2,206	7,871	15,641	8
9	SNF/PED					9
10	ICF	32,413	14,471	16	46,900	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,977	16,677	7,887	62,541	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.82%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 5/ /60

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 54 and days of care provided 7,798

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: 11/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	469,487	23,988	13,296	506,771		506,771		506,771			1
2	Food Purchase		244,855		244,855		244,855	(1,248)	243,607			2
3	Housekeeping	214,808	32,462	39,746	287,016		287,016		287,016			3
4	Laundry	194,260	12,622	1,007	207,889		207,889		207,889			4
5	Heat and Other Utilities			213,064	213,064		213,064		213,064			5
6	Maintenance	72,702	19,797	64,006	156,505		156,505		156,505			6
7	Other (specify):*											7
8	**TOTAL General Services**	951,257	333,724	331,119	1,616,100		1,616,100	(1,248)	1,614,852			8
	B. Health Care and Programs											
9	Medical Director			38,280	38,280		38,280		38,280			9
10	Nursing and Medical Records	3,173,906	87,531	27,925	3,289,362		3,289,362		3,289,362			10
10a	Therapy	130,519	3,966	57,750	192,235		192,235		192,235			10a
11	Activities	134,074			134,074		134,074		134,074			11
12	Social Services	104,906	4,091		108,997		108,997		108,997			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,543,405	95,588	123,955	3,762,948		3,762,948		3,762,948			16
	C. General Administration											
17	Administrative	56,861		26,584	83,445		83,445	(26,584)	56,861			17
18	Directors Fees											18
19	Professional Services			24,130	24,130		24,130		24,130			19
20	Dues, Fees, Subscriptions & Promotions			46,379	46,379		46,379	(30,525)	15,854			20
21	Clerical & General Office Expenses	164,276	29,752	24,009	218,037		218,037	(987)	217,050			21
22	Employee Benefits & Payroll Taxes			1,109,084	1,109,084		1,109,084	(5,399)	1,103,685			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,269	21,269		21,269		21,269			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			65,628	65,628		65,628		65,628			26
27	Other (specify):*											27
28	**TOTAL General Administration**	221,137	29,752	1,317,083	1,567,972		1,567,972	(63,495)	1,504,477			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,715,799	459,064	1,772,157	6,947,020		6,947,020	(64,743)	6,882,277			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Rehab & Care Ctr-Jackson County #0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			335,235	335,235		335,235	(12,234)	323,001			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,769	18,769		18,769	(18,769)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							(2,131)	(2,131)			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			354,004	354,004		354,004	(33,134)	320,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		346,700		346,700		346,700		346,700			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,595	110,595		110,595		110,595			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		346,700	110,595	457,295		457,295		457,295			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,715,799	805,764	2,236,756	7,758,319		7,758,319	(97,877)	7,660,442			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,248)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,131)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,234)	30		9
10	Interest and Other Investment Income	(18,769)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(315)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(26,584)	17		24
25	Fund Raising, Advertising and Promotional	(30,525)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(6,071)	21,22		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (97,877)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (97,877)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Rehab & Care Ctr-Jackson County

ID# 0010330

Report Period Beginning: 12/1/01

Ending: 11/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending Income	$ (5,399)	22	1
2	Postage	(167)	21	2
3	Copies	(261)	21	3
4	Miscellaneous	(244)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(6,071)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 **Report Period Beginning:** 12/1/01 **Ending:** 11/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,248)	0	0	0	0	0	0	0	0	0	0	(1,248)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,248)	0	0	0	0	0	0	0	0	0	0	(1,248)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(26,584)	0	0	0	0	0	0	0	0	0	0	(26,584)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(30,525)	0	0	0	0	0	0	0	0	0	0	(30,525)	20
21	Clerical & General Office Expenses	(987)	0	0	0	0	0	0	0	0	0	0	(987)	21
22	Employee Benefits & Payroll Taxes	(5,399)	0	0	0	0	0	0	0	0	0	0	(5,399)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(63,495)	0	0	0	0	0	0	0	0	0	0	(63,495)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(64,743)	0	0	0	0	0	0	0	0	0	0	(64,743)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Rehab & Care Ctr-Jackson County** **#** **0010330** **Report Period Beginning:** **12/1/01** **Ending:** **11/30/02**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(12,234)	0	0	0	0	0	0	0	0	0	0	(12,234)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,769)	0	0	0	0	0	0	0	0	0	0	(18,769)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(2,131)	0	0	0	0	0	0	0	0	0	0	(2,131)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(33,134)	0	0	0	0	0	0	0	0	0	0	(33,134)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(97,877)	0	0	0	0	0	0	0	0	0	0	(97,877)	45

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Fifth Third Leasing Company		X	To replace and update Heating	$9,062.32	2/16/99	$ 822,746	$	11/16/09	0.0495	$ 18,769	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$9,062.32		$ 822,746	$			$ 18,769	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 822,746	$			$ 18,769	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rehab & Care Ctr-Jackson County COUNTY Jackson

FACILITY IDPH LICENSE NUMBER 0010330

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 150,000 B. General Construction Type: Exterior Brick Frame Concrete and Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	871,200	1960	$ 10,000	1
2					2
3	TOTALS	871,200		$ 10,000	3

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1960	1960	$ 1,069,483	$	30	$	$	$ 1,069,483	4
5			1966	1966	289,003		30			288,995	5
6	102		1972	1972	1,404,551		30			1,404,530	6
7											7
8											8
	Improvement Type**										
9	Parking Lots			1972	63,650		22.45			63,650	9
10	Building Improvements			1974	122,761		19.66			122,761	10
11	New Electric Cable			1979	7,903		15			7,903	11
12											12
13	Sprinkler System			1978	1,005	40	24.51	40		962	13
14	Building Improvements			1978	31,978		21.01			31,978	14
15	Air Conditioning			1979	8,150		19.98			8,150	15
16	Landscaping			1981	315		10			315	16
17	Fire Doors			1981	352		20			352	17
18	Electrical Work			1981	9,584		20			9,584	18
19	Electrical Wiring			1981	12,896		20			12,896	19
20											20
21	Air Compressor			1981	1,242		10			1,242	21
22											22
23	Hot Water Heating System			1982	15,222		15			15,222	23
24	Door Closer			1982	650		15			650	24
25	Fire Doors			1982	5,288		15			5,288	25
26	Roof Repairs			1982	322,299		15			322,299	26
27	Electric Work			1983	100,430		15			39,338	27
28	Electric Panel Modification			1983	1,002		15			1,002	28
29	Roof Repairs			1983	38,573		15			38,573	29
30	Fire Doors			1983	1,158	58	20	58		1,131	30
31	Air Handling Units			1984	1,166		10			1,166	31
32	Booster Pump			1984	1,085		10			1,085	32
33	Key Locks and Building			1984	1,592		15			1,592	33
34	Ground fault Recepticles			1984	1,022		15			1,022	34
35	Roof Repairs			1984	121,210		15			121,210	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Fire Alarm System	1984	$ 52,151	$	15	$	$	$ 52,151	37
38	Interior Aluminum Doors	1985	1,144	57	20	57		942	38
39	Storage Shed	1985	1,095	55	20	55		961	39
40	Exterior Doors	1985	1,635	82	20	82		1,352	40
41	Fire Doors	1985	3,822	191	20	191		3,343	41
42	Key Locks and Building	1985	359		15			359	42
43	Ceiling Tiles	1985	957		15			957	43
44	Building Repair	1985	1,999		15			1,999	44
45	Fire Alarm System	1985	1,086		15			1,086	45
46	Heating System	1985	137,183		15			108,616	46
47									47
48	Call Light System	1985	19,148		15			19,148	48
49	Heating System	1986	2,418	121	20	121		1,996	49
50	Generator	1986	28,546	1,427	20	1,427		23,547	50
51	Emergency Generator	1986	15,400	770	20	770		12,705	51
52	Roof Repairs	2002	279,610	1,553	15	1,553		1,553	52
53	Dietary Renovation-Conveyor	1987	5,083	168	15	168		5,083	53
54	Dietary Renovation-Refrig/Freezer	1987	25,083	1,254	20	1,254		19,437	54
55	A, B, &C Renovations	1987	337,164	16,858	20	16,858		261,300	55
56	Vinyl Flooring	1987	29,000	1,450	20	1,450		22,475	56
57	Dietary Renovations	1987	276,810	13,841	20	13,841		214,522	57
58	A, B, &C Renovations Final	1988	1,521	76	20	76		1,102	58
59	Dietary Renovations	1988	815	41	20	41		593	59
60	Roof Repairs	1989	16,485	1,099	15	1,099		14,837	60
61	Transfer Switch	1989	6,425	321	20	321		4,335	61
62	Kickplates	1989	1,685	112	15	112		1,513	62
63	Laundry Renovations	1989	187,559	9,378	20	9,378		126,603	63
64	Sprinkler	1990	3,150	126	25	126		1,575	64
65	Lockers	1990	4,233	212	20	212		2,649	65
66	Earthquake Valves	1990	5,648	282	20	282		3,526	66
67	Security System	1990	1,798	120	15	120		1,500	67
68	Cubicle Track	1990	5,729	382	15	382		4,775	68
69	Screens	1991	1,804	120	15	120		1,381	69
70	TOTAL (lines 4 thru 69)		$ 5,090,115	$ 50,194		$ 50,194	$	$ 4,490,300	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,090,115	$ 50,194		$ 50,194	$	$ 4,490,300	1
2	Kickplates	1991	1,531	102	15	102		1,173	2
3	Medical Ancillary Center	1991	1,448	72	20	72		829	3
4	Boilers & Cooling Tower	1991	18,057	903	20	903		10,384	4
5	Asbestos removal	1991	26,516		10			26,516	5
6	Hazmat Storage Building	1992	1,485	74	20	74		780	6
7	Boilers & Cooling Tower	1992	289,332	14,467	20	14,467		152,150	7
8	Asbestos removal	1992	17,956	895	10	895		17,956	8
9	Engineering Study-Electrical Work	1992	16,098	805	20	805		8,452	9
10	Paging System	1993	4,385	292	15	292		2,775	10
11	Case Work Replacement	1993	85,585	4,279	20	4,279		40,652	11
12	Floor Tile/Vinyl Flooring/Fire Door	1993	34,880	1,744	20	1,744		16,568	12
13	Sealant	1993	16,150	646	25	646		6,137	13
14	Shelter	1993	7,995	400	20	400		3,798	14
15	Chain Link Fence	1993	4,990	333	15	333		3,160	15
16	Parking Lot	1993	29,310	1,954	15	1,954		18,563	16
17	Outside Lights	1993	18,839	1,256	15	1,256		11,931	17
18	Curbing & Sidewalks	1993	6,820	341	20	341		3,240	18
19	Sidewalk Extension	1994	4,999	250	20	250		2,125	19
20	Resurface & Striping	1994	1,543	103	15	103		874	20
21	HVAC System	1994	4,570	229	20	229		1,945	21
22	Boiler Room	1994	34,821	1,741	20	1,741		14,799	22
23	Floor Tile/Vinyl Flooring/Fire Door	1994	4,999	250	20	250		2,125	23
24	Masonry Work	1994	4,840	194	25	194		1,648	24
25	Sealant	1994	850	34	25	34		289	25
26	Visual Observation System	1994	60,480	4,032	15	4,032		34,272	26
27	Telephone System	1995	16,928	846	20	846		6,346	27
28	Boiler Room	1995	5,379	269	20	269		2,017	28
29	Safety Wire Glass	1995	2,600	173	15	173		1,299	29
30	Tuckpointing & Waterproofing	1996	1,800	72	25	72		468	30
31	Metal Fire Door	1996	1,785	89	20	89		580	31
32	Repair to Electric Facilities	1996	5,176	259	20	259		1,683	32
33	Shelving	1996	3,680	184	20	184		1,196	33
34	TOTAL (lines 1 thru 33)		$ 5,825,942	$ 87,482		$ 87,482	$	$ 4,887,030	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,825,942	$ 87,482		$ 87,482	$	$ 4,887,030	1
2	Fire Doors	1997	707	35	20	35		194	2
3	Counter Top-Gray Essences	1998	784	52	15	52		186	3
4	Carpet-Bus Off, NSG. Admin., Chapel	1998	4,047	809	5	809		3,855	4
5	Metal Fire Retardant Door-Dietary	1998	2,912	146	20	146		644	5
6	Fuel Tank Removal and Upgrade	1998	85,056	4,253	20	4,253		20,215	6
7	Side Rails	1998	2,697	180	15	180		860	7
8	Smokers' shelter 10x21	1999	1,671	167	10	167		525	8
9	Patio	1999	1,000	100	10	100		339	9
10	Chain Link Fence extension	1999	510	34	15	34		116	10
11	Ceiling Tiles	1999	557	70	8	70		231	11
12	Mini-Kitchen	2000	3,342	167	20	167		492	12
13	HVAC	2000	2,039,563	135,971	15	135,971		272,314	13
14	Patio	2000	2,612	261	10	261		587	14
15	Rollup Curtains-Cabana	2001	2,820	282	10	282		423	15
16	Landscaping	2001	3,283	328	10	328		383	16
17	Handrails (220 LF)	2001	2,114	140	15	140		235	17
18	Ceiling Tiles	2001	1,689	113	15	113		169	18
19	Roof Repairs	2001	700	47	15	47		74	19
20	Window Pictorials for Cafeteria	2001	3,554	355	10	355		385	20
21	Floor Tile-E&F Solarium	2001	2,175	109	20	109		163	21
22	Floor Tile-D Unit	2001	7,265	363	20	363		545	22
23	Ceiling Tiles	2001	325	22	15	22		29	23
24	Floor Tile-E Unit	2001	7,510	376	20	376		501	24
25	Handrails (360 LF)	2001	3,515	234	15	234		293	25
26	Knoblocks (2-Corbin Grade 1)	2001	564	38	15	38		47	26
27	Floor Tile-G Unit	2001	17,110	856	20	856		856	27
28	Steamer	2001	24,080	2,408	10	2,408		4,615	28
29	Marquee Sign	1995	4,491	449	10	449		3,367	29
30	Dining Room Curtains & Tension Rods	2002	563	94	5	94		94	30
31	Interior Fuse Panel with Breakers	2002	1,850	69	20	69		69	31
32	Supply Line for Steam Table	2002	377	14	20	14		14	32
33	Climate Control Basic Compressor 216QRBL	2002	1,029		15				33
34	TOTAL (lines 1 thru 33)		$ 8,056,414	$ 236,024		$ 236,024	$	$ 5,199,850	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 884,337	$ 81,405	$ 81,405	$	*5-20	$ 564,918	71
72	Current Year Purchases	29,699	1,250	1,250		*3-20	1,250	72
73	Fully Depreciated Assets	694,591	4,322	4,322		*5-20	694,591	73
74								74
75	TOTALS	$ 1,608,627	$ 86,977	$ 86,977	$		$ 1,260,759	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 9,675,041	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 323,001	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 323,001	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,460,609	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Medical Ancillary Complex 1990	$ 107,276	$ 5,364	$ 67,049	86
87	HVAC Project	103,052	6,870	13,759	87
88					88
89					89
90					90
91	TOTALS	$ 210,328	$ 12,234	$ 80,808	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	111	$ 3,800	$ 1,797	111	$ 5,597	1
2	Licensed Speech and Language Development Therapist		hrs		474	19,080	1,103	474	20,183	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/8	2088 hrs	55,403	663	14,401	1,066	2,751	70,870	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/8	# of prescrpts				176,659		176,659	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): VA LAB, Med Supply						170,041		170,041	13
14	TOTAL			$ 55,403	1,248	$ 37,281	$ 350,666	3,336	$ 443,350	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Rehab & Care Ctr-Jackson County **#** 0010330 **Report Period Beginning:** 12/1/01 **Ending:** 11/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 11/30/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 915,998	$	1
2	Cash-Patient Deposits	37,547		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 96,653)	1,598,339		3
4	Supply Inventory (priced at)	6,050		4
5	Short-Term Investments	96,903		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,006		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from other funds, Payroll	1,080,597		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,736,440	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	166,648		13
14	Buildings, at Historical Cost	8,110,092		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,608,627		16
17	Accumulated Depreciation (book methods)	(6,541,416)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,343,951	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,080,391	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 159,146	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	37,547		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	430,923		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Deferred Revenue	179,017		36
37	Accrued DPA Assessment	(9,393)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 797,240	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 797,240	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,283,151	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,080,391	$	48

***(See instructions.)**

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 7,014,144	1
2	Restatements (describe):		2
3	**Revaluation of Fixed Assets**	14,979	3
4	**Additions to Contributed Capital**	87,854	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 7,116,977	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(833,826)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (833,826)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,283,151	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,761,139	1
2	Discounts and Allowances for all Levels	(923,685)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,837,454	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,248	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,131	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,379	23
	D. Non-Operating Revenue		
24	Contributions	165	24
25	Interest and Other Investment Income***	74,137	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 74,302	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	244	28
28a	Copies, Postage, Vending	9,114	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,358	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,924,493	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,616,100	31
32	Health Care	3,762,948	32
33	General Administration	1,567,972	33
	B. Capital Expense		
34	Ownership	354,004	34
	C. Ancillary Expense		
35	Special Cost Centers	346,700	35
36	Provider Participation Fee	110,595	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,758,319	40
41	**Income before Income Taxes (line 30 minus line 40)****	(833,826)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (833,826)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,088	$ 57,974	$ 27.77	1
2	Assistant Director of Nursing	1,948	2,088	48,639	23.29	2
3	Registered Nurses	38,439	43,103	760,547	17.64	3
4	Licensed Practical Nurses	23,592	26,332	586,347	22.27	4
5	Nurse Aides & Orderlies	110,255	117,927	1,638,241	13.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,944	2,088	55,403	26.53	7
8	Rehab/Therapy Aides	13,208	14,636	157,273	10.75	8
9	Activity Director	1,868	2,088	44,557	21.34	9
10	Activity Assistants	8,319	9,535	88,425	9.27	10
11	Social Service Workers	6,570	7,054	105,998	15.03	11
12	Dietician					12
13	Food Service Supervisor	1,984	2,088	46,142	22.10	13
14	Head Cook	2,000	2,088	36,453	17.46	14
15	Cook Helpers/Assistants	35,315	37,931	386,892	10.20	15
16	Dishwashers					16
17	Maintenance Workers	7,248	8,460	72,702	8.59	17
18	Housekeepers	15,978	17,810	214,808	12.06	18
19	Laundry	15,331	17,031	194,260	11.41	19
20	Administrator	1,800	2,088	56,861	27.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,844	2,088	42,674	20.44	23
24	Clerical	9,513	10,177	121,602	11.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,020	326,700	$ 4,715,798 *	$ 14.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 13,296		35
36	Medical Director	480	38,280		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Quality Assessment		1,350		46
47	Dental Consultant	240	19,975		47
48	Psych Consultant		4,200		48
49	TOTAL (lines 35 - 48)	816	$ 79,501		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Merle K. Taylor	Nursing Home Administrator	0	$ 56,861
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 56,861

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kerber, Eck, and Braeckel	Cost Report and Audit	$ 3,625
Duane Morris	Attorney Fees	17,194
Jackson County	Salary	2,931
FR & R Healthcare Consulting, Inc.	M'care Consulting	380
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 24,130

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 112,459
Unemployment Compensation Insurance	11,769
FICA Taxes	306,044
Employee Health Insurance	568,280
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	69,454
Employee Physical Exams	2,744
Employee Dental Ins	9
Employee Relations	32,926
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,103,685

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,791
Health Care Worker Background Check	
(Indicate # of checks performed)	
Books And Subscriptions	3,051
Marketing	26,734
Licenses and Dues	12,381
HCFA Lab Certification	150
Sam's Club Mamabership & Misc.	272
Less: Public Relations Expense	(26,734)
Non-allowable advertising	(3,791)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,854

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 1,632
In-State Travel	1,779
Mileage paid for various employees	3,229
for travel	
Seminar Expense	14,629
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,269

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/1/01 Ending: 11/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Rehab & Care Ctr-Jackson County **#** 0010330 **Report Period Beginning:** 12/1/01 **Ending:** 11/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **CNHA & IHCA $12,381**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **15**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. **No**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **110,595 Lic. Bed Tax**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Kerber, Eck & Braeckel LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit in process; will send when comp**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.